ATTACHMENT A

PRINT EMPLOYEE NAME: _____ **TITLE:** _____

INFLUENZA VACCINATION FORM

○ I have already received the Influenza Vaccine and submitted documentation to support this.

Date immunized: _____

Individual who administered Influenza Vaccine:

Name: _____ Title: _____

Address: _____

Telephone: _____

○ I have not receive the Influenza Vaccine.

☐ I am declining the Influenza Vaccine for the following reasons: ☐ Medical ☐ Religious ☐ Personal

I have been informed that it is mandatory for me to wear a surgical mask and I agree to wear a mask upon entering patient's home for the duration of my visit in order to prevent contraction and/or transmission of infectious air borne materials.

☐ For medical reasons, must have NYC DOH 4482 form filled out by physician, physician assistant, nurse practitioner, nurse-midwife, or licensed midwife.

☐ I understand that by declining the influenza vaccine I continue to be at risk of acquiring influenza virus, if, in the future while employed by [redacted] I decide to be vaccinated for the influenza virus I am free to consult with my PCP and receive the vaccine.

☐ I have been informed where I can obtain Influenza Vaccine.

☐ I further understand that the agency will provide me with a surgical mask at no cost to me.

☐ I have received several masks from the agency and when needed will request additional masks.

☐ I acknowledge a red dot has been placed on my photo identification.

EMPLOYEE SUGNATURE: _____ SIGN HERE **DATE:** _____

WITNESS SIGNATURE: _____ **DATE:** _____